THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF LABOR AND WORKFORCE DEVELOPMENT
DEPARTMENT OF INDUSTRIAL ACCIDENTS

THE MEDICAL SECURITY PROGRAM

Medical Security Program: Request for Hardship Waiver on Premium Payments

Name_____ Address_____ Last 4 S.S. number _____

QUALIFYING CRITERIA

Please check each of the qualifying criteria that apply to your personal situation and attach **copies of the appropriate documentation (for example, an electricity shut-off notice), as applicable**:

____ You are either homeless, more than 30 days in arrears in mortgage or rent payments, or have received a foreclosure or eviction notice.

____ You have received a shut-off notice from one or more of your utility providers, or one or more of your utility providers has refused to deliver services because you are unable to pay.

____ You have filed a petition for bankruptcy within the past six months.

____ You have experienced a significant increase in expenses during the past six months because of the death of a spouse, other family member, or partner who bore primary child-care responsibilities.

____ You have experienced a significant increase in expenses during the past six months as a consequence of a domestic violence situation.

____ You have experienced a significant increase in expenses during the past six months because of the responsibility of providing full-time care for an aging relative or paying for long-term nursing care for an ill or injured family member.

____ You have experienced a significant increase in expenses during the past six months because of a natural disaster or other unexpected event that damaged your home or personal possessions.

____ You have accrued qualifying medical and dental expenses – *not to include premiums* – during the past 24 months that exceed 7.5% of you family's annual gross income.

NOTE: *These medical and dental expenses must be for services provided to a member of your family, must be non-cosmetic in nature, and must have been incurred while you were enrolled in MSP.*

Signature _____ Date_____

Please mail or fax your completed form to the following:

Medical Security Program
Hardship Waiver Requests
P.O. Box 146758
Boston, MA 02114-0020
FAX: 617-626-5538

2/9/2012